MINUTES

COMMITTEE ON EMPLOYEE HOSPITAL AND MEDICAL BENEFITS

Thursday, October 5, 2011
11:00 a.m.
Room 1228, Legislative Building

The Committee on Employee Hospital and Medical Benefits met October 5, 2011, at11:00 a.m. in Room 1228 of the Legislative Building. Senators Garrou, Harrington, Hise; Representatives Dollar, Earle, Murry, Stevens, Dockham and Tolson attended.

Representative Dockham presided. He welcomed the committee members and public and recognized the Sergeant-at-Arms, Bill Bass and Larry Elliot.

PRESENTATIONS

State Health Plan for Teachers and State Employees Financial Update

Lacey Barnes, Interim Executive Administrator

Ms. Lacey Barnes, Interim Executive Administrator of the State Health Plan, was introduced to discuss the FY 2010-2011 and August YTD Financial Reports. Ms. Barnes instructed the committee to refer to page two of the Committee on Employee Hospital and Medical Benefits spiral bound handout. Ms. Barnes stated that the State Health Plan had a good year from a fiscal standpoint. The Plan's expenses, both medical and administrative, were 3.9% less than projected in total dollars and 4.2% less on a per member basis. Both are attributed to the Comprehensive Wellness Initiative and to a decrease in utilization, which could be credited to the down economy. The Plan's ending cash balance was $269.8; which was $43 million more than was forecasted in SB 323/HB 578. Because there was a postponement in implementing changes in the spring of 2011, the cash balance enabled the Plan to fund the two months delay in changes in benefits. It also enabled the Plan to finance the free or no premium 70/30 plan. Ms. Barnes instructed the committee to move to the document titled "Adjusted Variance Report Year to Date August 2011" in the Committee on Employee Hospital and Medical Benefits spiral bound handout. She noted a beginning cash balance of $269.8. Plan revenue is $35 million short of planned revenue which is attributed to two things; premium changes have not taken place yet and the early retiree reinsurance program. The Plan budgeted to receive $25.5 million in July from this fund. The U.S. Health and Human Services Department is administrating this fund and they changed some of the fundamental requirements on the claims file layout in order for the State Health Plan to collect some of the $5 billion that covered early retirees and they have not paid anyone under that program since March of 2011. The State Health Plan has amended the file layouts and

has successfully submitted a new claims file, it is expecting a little over $42 million in reimbursements, hopefully within the next eight weeks. Net claims payments are under forecasted by $5.8 million which is attributed to deductibles and coinsurance that were reset July 1, 2011. It can also be attributed to the economy. Net Administrations Expenses are a little over budget by $0.2 million, but Ms. Barnes believes they are in good shape, but will be monitored. Total Plan expenses are $5.6 million under due to positive variance in the claims line. Net income and net loss is higher than projected by $29.4 million and that is associated with delay in premium increases, delay in R.R.P. payment and delay in benefits changes. Ending cash balance is $214.5 million as opposed to the certified budget of $200.9 million.

Senator Garrou was recognized to ask where the $40 million lost from removing the Comprehensive Wellness Initiative can be seen in the budget. Ms. Barnes responded that it was incorporated in the revised budget and flows through it; there is not a line item for the change and absence of the Comprehensive Wellness Initiative. Senator Garrou was recognized for a follow up question. She asked, if we had left in the Comprehensive Wellness Initiative, would the Plan have an additional $40 million and a balance of $53 million. Ms. Barnes responds that this is a possibility, but it depends on the flow and enrollments based on past performance. The Chair recognized Representative Dollar. Rep. Dollar asked if it may or may not be the case that we would have an extra $53 million if the Comprehensive Wellness Initiative was kept and at what point in time we will be able to calculate a savings or reduction from the Comprehensive Wellness Initiative. Ms. Barnes responded that the savings from the Comprehensive Wellness Initiative were not a reduction in total cost; it was transference of cost between those people that moved to the 70/30 plan because they didn't meet requirements of the Comprehensive Wellness Initiative and therefore were not eligible for the 80/20 plan.

Enrollment and Members Report

Caroline Smart, Director of Health Plan Operations

Ms. Caroline Smart was introduced to discuss how the State Health Plan enrollment and distribution between the 70/30 plan and the 80/20 plan have evolved and how that will affect the Plan in a couple of years. Ms. Smart instructed the committee to turn to page eight of the membership report in the Committee on Employee Hospital and Medical Benefits spiral bound handout. Looking back at June of 2010, prior to the Comprehensive Wellness Initiative, approximately 7% of membership was enrolled in the 70/30 plan. In July of 2010 the Tobacco Cessation component was implemented and the Plan saw a shift to 22% in the 70/30 plan. In July of 2011 the Plan implemented the weight management component and saw a total shift to 30% in the 70/30 plan. Enrollment in the State Health Plan occurred again on September 1, 2011 with the absence of the Comprehensive Wellness Initiative but no final numbers are available yet to indicate how many members stayed in the 70/30 plan or moved back to the 80/20 plan. From data that has been collected it appears that the same 30% has remained in the 70/30 plan. Senator Hise was recognized to ask if all the costs savings from the Comprehensive Wellness Initiative were based on the shifting of the members to the 70/30 plan. Ms.

Smart responded that not all of them could be based on the Comprehensive Wellness Initiative. Senator Hise was recognized for a follow up question. He asked, was little or no loss to the State Health Plan because of the absence of the Comprehensive Wellness Initiative? Ms. Smart responded that they do not have enough data to answer that question until later in the year and they will also not know the impact of the premium for the 80/20 plan until later in the year. Representative Dollar was recognized to ask, when numbers come back and it shows that we are still at 30% then there is really no loss from the absence of the Comprehensive Wellness Initiative. Ms. Barnes responded the Comprehensive Wellness Initiative was a mechanism by which those members who used tobacco or were obese were put into the 70/30 plan. Those members who use tobacco products and are obese are at higher risk for health complications and therefore higher costs for the State Health Plan. Those members then were put into the 70/30 plan so the Plan has a lower liability. Since the Plan has eliminated the Comprehensive Wellness Initiative and introduced a premium, the Plan will have a reverse effect potentially. Those members at risk are now free to choose the 80/20 plan but there is now a premium. Those who are more likely to need more medical attention will apt for the 80/20 plan. Families who are interested in affordability are more likely to choose the 70/30 plan with no premium. The State Health Plan is interested in watching who moved where and what the risk pool looks like in each Plan.

Representative Dockham asked if there appeared to be a large number of members transferring to the 80/20 plan. Ms. Barnes responded that no, there was not a mass exodus to the 80/20 plan. Representative Earle was recognized to ask if there was a projection of what could be saved if both elements of Comprehensive Wellness Initiative were applied to members. Ms. Barnes responded that there are two components of savings and they were both looked at. First, the change of the out of pocket cost. At the beginning, before the tobacco element was instated, it was estimated at $13 billion to the Plan. There is a great deal of study that offers estimates that lifestyle changes and worksite wellness initiatives are the only real key to bend the cost curve. Representative Earle was recognized for a follow up question inquiring about a shift in membership. Ms. Barnes responded that 70% of members are enrolled in the 80/20 and 30% in the 70/30 plan. Ms. Barnes reiterated that they are not sure which members are in what plan, and that they will be interested to see when the data is available. The Chair recognized Representative Murray. Representative Murry asked if state employees lost weight and stopped smoking under the Comprehensive Wellness Initiative. Ms. Barnes responded that Anne Rogers, Director of Integrated Health Management for the State Health Plan, will discuss increase of quit line usage of the Eat Smart, Move More, and Weigh Less pilot incentive programs. Ms. Barnes continued by saying that most claims data does not reflect weight, just smaller groups where data could be offered is weight a factor. Representative Dollar was recognized to ask about incentive programs. Ms. Barnes responded that this information would be discussed later in the meeting.

Audit Reports

Lacey Barnes, Interim Executive Administrator

The Chair recognized Ms. Lacey Barnes to discuss the recent audits. The office of the NC State Auditor initiated two audits last summer. One was characterized as an overall risk assessment of contracting abilities. The other specific audit related to outpatient services at Baptist Hospital. The audits were not released until September of 2011. The audit of Baptist Hospital dealt with outpatient services and the way that those services were paid for under the indemnity plan, which is no longer in place, between the years 2003 and 2008. The billing is done on a discounted fee for services. The provider submitted claims and the State Health Plan had a discount that was applied to the fee to realize a certain net savings. That applied across the board to all hospitals. Almost all of those contracts included an obligation on the part of the hospital to report changes in the fee schedule to the plan. Baptist Hospital did not have that particular requirement. The Plan needed to know if a provider changed their fee schedule, or increased it, because if they increased the fee more than the medical inflation factor, then the Plan had a contractual right to increase its discount to maintain the same payment. Not having done that, there was the possibility the Plan might have overpaid hospitals. The SHP conducted an audit of all hospital contracts and found that some of the hospitals had duly notified the Plan and all payments were correct. We found that some hospitals had not notified us and their payments were not correct. We also found that some hospitals had not notified us but their payments did not increase more than the medical inflation factor. There were some reports in the media that Baptist Hospitals defrauded the State Health Plan, but Ms. Barnes assured the members that this is not the case. Ms. Barnes could not tell the members why in 2003 the Plan did not have a requirement to notify the Plan of its changes in the fee schedule. The State Health Plan has significantly changed its contracting processes, policies and procedures and place. The Plan is not currently holding provider contracts. Ms. Barnes assured the members that these issues will not take place in the future.

The other audit was a risk audit of total contracting capabilities. The auditor's office reviewed contracts and amounts paid under each contractor; the biggest contract is with Blue Cross Blue Shield, as they process the Plans medical claims. The Plan retains an outside audit firms that conducts quarterly audits for payment and accuracy. The audit reported that in the years 2008, 2009 and 2010 payment errors totaled $48 million, which is less than 1% of total payments. The Plan agrees that identification of root causes or errors and appropriate follow through on corrective action plans are critical. The Plan has reorganized internally and increased its monitoring capabilities. Director of Health Plan Operations, Caroline Smart, was recruited to identify important changes the Plan is implementing. The Plan has devoted additional resources to monitoring performance targets and has engaged our vendor in improvement plans under the existing contract. Toward that end, work is underway on a request for proposal that will form the basis of a competitively bid contract that will go into effect when the current contract expires July 1, 2013. While the initial draft is still being prepared by the Plan's staff, the Plan will partner with external experts and consultants to ensure that the next contract is

technically sound. Senator Hise was recognized to ask if there was a breakdown by specific contracts for the $48 million that was overpaid in regards to administrative costs. Ms. Barnes responds that $48 million is all medical claims expenses that have been paid by Blue Cross Blue Shield to providers. None of the $48 million are administrative costs; it is all attributed to claims. There were over and underpay errors. Senator Hise followed up asking, is the administrative costs for the Plan a percentage of claims or a number of claims filed? Ms. Barnes responded "neither" because Blue Cross Blue Shield is a contract plus arrangement, meaning, administrative costs is based on actual costs to administer it, not a per claims basis. Representative Dollar was recognized to remark that the poor quality of contracting as a whole has cost the state hundreds of millions of dollars that needs attention. Representative Dollar asked for a written update on where the Plan is and what actions it has taken on the specific audit findings. He also asked if the Plan was looking at doing a cost plus contract again. Ms. Barnes responded the Plan will not do a cost plus contract again. Representative Dockham remarked that this was the last meeting but that Ms. Barnes could provide a written update regarding the Plan's changes generated from the audit for the members of the committee.

Strategic Management Update

Carol Durrell, Director of Product Development

Ms. Carol Durrell focused on the Request for Proposal (RFP) approach and how product design and strategy will be incorporated into that process. The Blue Cross Blue Shield North Carolina contract with the Plan expires on 6/30/2013, but the Plan will need to have a contract awarded by 7/1/2012 to be fully prepared for the 7/1/2013 effective date. The Third Party Administer (TPA) RFP is in essence many RFP's rolled into one. The approach is flexible to allow for contracting with one or more vendors, which allows the Plan to evaluate vendors based on the best practices. With the transition of the State Health Plan governance to the Department of the State Treasurer, and a Fiduciary Board of Trustees, the Plan and Department of the State Treasurer are working closely to prepare for the transition. Product strategy is in process as well and a very important aspect of the RFP. The State Health Plan is evaluating a wide array of potential offerings to, both Actives and Non Medicare Retirees and Medicare Retirees, and working with their actuaries and consultants. The Plan will integrate all those components in the RPF since that will be effective 7/1/13 and the contract will be award in August of 2012. The Plan will be presenting recommendations to the new Board of Trustees sometime after January 1, 2012. The Plan is also working on other proposals. They do realize new contract development is critical to the administration to the Plan. Senator Hise was recognized to ask if the Plan was looking at minimum standards for coverage area for distance from network and availability of services in the RFP. Ms. Durrell stated they would work with their consulting company to determine network strategy and development and if the Plan wanted to approach networks on a full state basis or with various service areas or vendors. Ms. Durrell stated this was to be determined. Senator Hise was recognized to ask how much emphasis the Plan would place on meeting grandfather requirements under the Affordable Care Act or if companies could bid and not use the grandfather status in their contracts. Ms. Durrell said they anticipated the loss

of the grandfather status at some point before 2014, so the Plan is not ruling out bids that won't be grandfathered. Representative Dockham asked for an update on Medicare Advantage. Ms. Durrell stated that SB 323/HB 528 mandated the Plan to complete Medicare Advantage RFP no later than June of 2012. Medicare Advantage is certainly something being looked at in relation to project strategy and it will be included as a separate section in the TPA RFP. Representative Dockham responded that he believes this will save the state a lot of money and requested the Plan administrators to make it happen as quickly as possible. Ms. Durrell commented that the Plan administrators agree with Representative Dockham.

Ms. Durrell presented a Segal Study Update. The State Health Plan engaged The Segal Company through a RFP process to study the Plan's Ten Year Strategy. The purpose of the study was to recommend programs and benefits to support the strategy and to recommend approaches to measure the success of the program over time. Segal presented the recommendations to the Plan's Executive Team on May 23, 2011. The Segal study acknowledged the Plan's proactive approach to wellness and disease and care management programs. Segal also acknowledged that to bend the medical trend, the Plan needed to take an integrated 'carrot and stick' approach. A carrot might be a reduced primary co pay and a stick may be a premium surcharge for smokers. Specific recommendations include were promoting the use of patient centered medical home. Another recommendation was a benefit design to support certain Centers of Excellence, known for quality for particular illness such as cardiac and hip replacement. They also designed and recommended several specific "healthy activity" programs that were coupled with either incentives for completing the healthy activities or penalties for not completing the activities. Many of these programs have been implemented as a pilot program which Anne Rogers will discuss later. Representative Murry was recognized to suggest that the Plan look at consumer driven health plan designs. He suggested adding options that are provided in the private sector. Representative Dollar was recognized to ask if the Plan was looking at Community Care of North Carolina. He believes this could offer tremendous savings to the Plan. Ms. Anne Rogers suggest that she will cover this in her presentation; however, the Plan is aware of the savings and benefits of using these types of projects and being able to use local case management and care management services.

Pharmacy Report

Sally Morton, PharmD, Clinical Pharmacist

Ms. Sally Morton was invited to speak to the pharmacy report. In accordance with Session Law 2009-16, Senate Bill 287, Section 2 (h) Pharmacy Benefits Savings, the Plan has been working with the Pharmacy Benefit Manager to achieve the required savings for pharmacy prescription costs in the sum of twenty million dollars in savings for the fiscal year 2010-2011. The savings have been realized through decreased reimbursements paid to pharmacies for prescription medications. The Plan must report twice annually to ensure compliance with session law. Session Law 2009-16, Senate Bill 287, Section 2 (h) mandates if the savings achieved in each six month period of the fiscal year do not

exceed one hundred five percent of the savings amount specified in the session law for that fiscal year, there shall be no further adjustment to reimbursements paid to pharmacies for that six month period. The Plan requested that its consulting actuary review its Pharmacy Benefit Manager's savings according to session law. The report shows that the Plan saved $19.9 million in this period versus a goal of $20 million.
Representative Earle was recognized to ask a question regarding prescription drugs. She has had two pharmacies in her district contact her in regards to specialty drugs. Patients have to go through mail order to get specialty drugs and the state has contracted with one company, CVS. Ms. Morton responded that the Plan contracted with Accredo Specialty pharmacy to dispense specialty drugs in July of 2009. Members can get acute specialty drugs at any pharmacy and any oncology drugs at any pharmacy. The Plan did do a study regarding specialty drugs, which are drugs with an average monthly cost of $3,000, to see how we could improve care management for the members and bring down costs. They found that if they used one vendor they could offer a better quality of care and monitor members, as well as look at reimbursement strategy. Ms. Barnes also spoke on channel management in response to Representative Earle's question.

Representative Murry was recognized to suggest that the Plan allow other state pharmacies to provide specialty drugs if they choose to participate. Representative Stevens asked if these programs are working effectively, why they are not opened for everyone else. Ms. Morton explained the Medication Adherence Pilot Program (MAPP) for Retirees. The MAPP was started in December of 2009 to increase the rate of medication adherence and close clinical gaps in care for retirees suffering from diabetes and cardiovascular conditions by using Medco specialized pharmacists. NC Walgreens stores were added to the program in August of 2010 and Boone Drug and Affiliates were added in November of 2010. All generic and brand diabetes and cardiovascular medications are eligible for 2.5 times co-pay for a 90 day supply at Medco by mail, North Carolina Walgreens stores and Boone Drug & Affiliates. Through August of 2011, MAPP has saved members $930,000 in copays and saved the State of NC $2,020,000 in pharmacy Plan cost. This was accomplished through reduced reimbursement and the Plan would love to expand this program to the active members and further classes of medications. The Plan is exploring all of the options. Representative Dollar was recognized to comment that numerous pharmacies did not get word to join this program. He then asked if other pharmacies could be added. Ms. Morton said they were not accepting new pharmacies, but they are looking at expanding the pharmacies and it will be opened again.

Integrated Health Management Report

Anne Rogers, Director of Integrated Health Management

Ms. Anne Rogers was recognized to explain the incentive pilots. The Plan is looking to increase the member's awareness of their health status and encourage them to engage in healthy lifestyle behaviors. The Plan is engaging in value based incentive programs. The first incentive discussed was the Murdoch and DHHS Expansion pilot. Around 1,175 participants received a reduction in primary care co-pay with biometric screenings and

HRA participation. Focus groups with participants allowed them to express the need they have for help with co-pays. After six months, there was an increase in PCP visits (+9%), a decrease in inpatient admissions (-6%), and a decrease in ER visits (-4%). Three additional worksites will be offered this pilot with an additional 2,000 employees to begin biometrics in November. Another incentive program is the Charlotte-Mecklenburg Schools pilot. Members will be provided with a co-pay reduction but they will be asked to take a biometric screening, a health assessment and engage in a healthy action step. The maternity incentive program is called the Stork Rewards pilot. This pilot began October 1, 2011 and was for all adult SHP pregnant women. A co-pay waiver of delivery admission was offered throughout the program to identify and address high risk pregnancies early on. The Department of Correction pilot engaged around 145 DOC employees with challenging work schedules and asked them to complete biometric screenings and 1:1 coaching sessions. The outcomes included a reduction in the number of participants with hypertension by 34%; BMI reduction from an average of 34.5 to 33.8; decrease in the number of predicted cases of stroke by 12%; 96% reported improved health status. To establish a culture of wellness at a worksite, it is essential the pilot gets the support of the management. QuitlineNC resulted in 3,112 members in a multi-call program with 3,544 NRT prescriptions distributed. A study showed that members were twice as likely to quit as others as a result as the combination coaching and NRT use. Eat Smart, Move More, Weigh Less is another pilot incentive program hosted by NC SHP. 3,999 members enrolled in 222 onsite worksite classes through June of 2011. 148 members enrolled in the online classes with a 57% completion rate and 9.7% average weight loss. Carolina Advanced Health is collaboration between UNC and BCBS to establish a multidisciplinary patient centered medical home in the Durham/Orange county area. This practice will be testing an alternative payment methodology with shared savings to the practice and it will be based on outcomes. This is in the early stages. The SHP is working out the details but the Plan is hoping to get 1,500 members in the program. There will be a co-pay reduction or waiver offered as an incentive. Representative Dollar was recognized to ask if the DOC pilot will be expanded. Ms. Rogers answered that it is difficult to organize these pilots in such high security settings. The Plan will begin an educational campaign in other areas to engage members in NC Health Start Programs.

Representative Dockham commended the committee for staying for the entire meeting and thanked the speakers for their thorough presentations.

No future meetings were scheduled. The Committee adjourned at 12:35 p.m.

Representative Jerry C. Dockham	Nicole McGuiness
Presiding Chair	Committee Assistant